Health Benefits Claim Form

Please mail completed form to:
HealthSmart Benefit Solutions ■ P.O. Box 3262 ■ Charleston, WV 25332 ■ Toll Free 800.624.8605

Patient's Information

Claim Is Made For
○ Husband ○ Unmarried Son/Daughter
○ Wife ○ Other
○ Self

Patient's Name (First, Initial, Last)

Date of Birth

Sex
○ M ○ F

Full-Time Student Attending (School Name)

Expected Date of Graduation

If Injury Is Due To An Accident

Date of Accident

Place of Accident

Briefly Describe Accident

Was patient at work when accident occurred?
○ Yes ○ No

Was the accident due to someone's negligence?
○ Yes ○ No

Other Insurance/Medicare

Any other medical benefits for employee, spouse, or patient?
○ Yes ○ No

If yes, who?
○ Self ○ Spouse ○ Dependent

If Dependent or Spouse, Full Name

Date of Birth

Coverage Paid Through
○ Medicare ○ Medicaid ○ Other
○ Employer-Sponsored Plan ○ Private Policy ○ CHAMPUS

Effective Date of Coverage

Last Day of Effective Coverage

Name of Other Insurance Company

Phone Number of Other Insurance Company

Please attach other insurance explanation of benefits, if applicable.

Employee's Information

Name (First, Initial, Last)

Social Security Number

Date of Birth

Sex
○ M ○ F

Address

City

State

ZIP

Employer's Name

Employer's Telephone Number

Group Number

Employment Status
○ Active ○ Retired
○ COBRA ○ Laid Off

Date Laid Off

Marital Status

Patient's or Authorized Person's Signature
I authorize the release of any medical information necessary to process this claim.

Signature

Date

Authorization for Payment of Medical Benefits
I hereby authorize payment of medical benefits to physicians or suppliers for services billed on this claim.

Signature (Insured or Authorized Person)

Employee's Signature

Date

I hereby certify the above information is true and correct.

Please do not
staple in this area

Health Insurance Claim Form

Medicare ○ (Medicare #) | Medicaid ○ (Medicaid #) | CHAMPUS ○ (Sponsor's SSN) | CHAMPVA ○ (VA File #) | Group Health Plan ○ (SSN or ID) | FECA ○ (SSN) | Other ○ (ID)

Insured's ID Number

Patient's Name (Last, First, Initial) | Patient's Date of Birth (MM/DD/YY) | Sex ○ M ○ F | Insured's Name (Last, First, Initial)

Patient's Address | Patient's Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other | Insured's Address

City | State | Patient's Status ○ Single ○ Married ○ Other ○ Employed Full-Time ○ Full-Time Student ○ Part-Time Student ○ Employed Part-Time | City | State

ZIP | Telephone | ZIP | Telephone

Other Insured's Name (Last, First, Initial) | Is patient's condition related to employment? (Current or Previous) ○ Yes ○ No | Insured's Policy Group or FECA Number

Other Insured's Policy or Group Number | Auto Accident ○ Yes ○ No | Accident Location | State | Insured's Date of Birth (MM/DD/YY) | Sex ○ M ○ F

Other Insured's Date of Birth (MM/DD/YY) | Sex ○ M ○ F | Other Accident? ○ Yes ○ No | Employer or School Name

Employer or School Name | Reserved for Local Use | Insurance Plan or Program Name

Insurance Plan or Program Name | Reserved for Local Use | Reserved for Local Use

Read front of form before completing and signing this form.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to me or to the party who accepts assignment below.

I authorize payment of medical benefits to undersigned physician or supplier for services described below.

Signature | Date | Signature

Date of Current Illness (First Symptom) , Injury (Accident) , Pregnancy (LMP) (MM/DD/YY) | If Patient Same or Similiar Illness (MM/DD/YY) | Date Patient Unable to Work in Current Occupation

Name of Referring Physician or Other Source | ID Number of Referring Physician | Hospitalization Dates Related to Current Services (MM/DD/YY) to (MM/DD/YY)

Repricer ID/Repricer Name | Outside Lab? ○ Yes ○ No | Charges $

Diagnosis or Nature of Illness or Injury 1 | 2 | Medicaid Resubmission Code | Original Reference Number

Diagnosis or Nature of Illness or Injury 3 | 4 | Prior Authorization Number

Date of Service From (MM/DD/YY)	Date of Service To (MM/DD/YY)	Place of Service	Type of Service	Procedures, Services, or Supplies (Explain unusual circumstances) CPT HCPCS Modifier	Diagnosis Code	Charges	Days or Units	EPSDT Family Plan	Repricing Method Code	Repriced Rejection Code	Repriced Amount

Federal Tax ID Number ○ SSN ○ EIN | Patient's Account Number | Accept Assignment ○ Yes ○ No | Total Charge $ | Amount Paid $ | Balance Due $

Signature of physician or supplier including degrees or credentials.
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Date

Service Facility Location Information | Billing Provider Information | Phone Number

NPI | NPI

Please Print or Type